David A. Tucker, MSAOM, L.Ac, LMP

9500 Roosevelt Way NE, Suite 301
Seattle, WA 98115

-PATIENT CONFIDENTIAL INFORMATION

1. Name First Middle Last
2. Address Street City State Zip
3. Home Phone: ______ 4. Business Phone: ______
   Cell Phone: ______ Extension: ______
5. Fax Number: ______ 6. Email: ______
7. Age ______ 8. Date of Birth ______ 9. Sex ______ 10. Marital: M S D W
11. Occupation ______ 12. Employer ______

Employer's Address ______
Street City State Zip

BRIEF CASE HISTORY

13. Chief Complaint ______
14. Complaint result of: Auto Accident Injury Job Related Other
15. Date of accident/Injury/Other ___ / ___ / ___
16. Have you seen any other doctor about this condition? ______ If yes, when? ______
17. Spouse's name ______ Occupation ______
    Employer ______ Address ______ Phone ______
18. Nearest relative not living with you ______
    Address ______ Phone ______
    Street City State Zip
19. In an emergency, call: Name Street City Phone

FOR FEMALES: Are you pregnant? ______ IF YES, HOW LONG? ______
FOR MINORS: List both parents' names and addresses

______

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? Cash Check Credit Card Health Insurance

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED ______ PATIENT'S SIGNATURE ______
(parent's signature if patient is minor)

Referred by ______

The Zen of Healing
David A. Tucker, L.Ac., L.M.P. - Informed Consent

9500 Roosevelt Way NE, Suite 301
Seattle, WA 98115

I, the undersigned, hereby authorize David A. Tucker to perform the following procedures:

- **Acupuncture:** The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
- **Moxibustion:** The direct or indirect warming of specific points using the herb mugwort (*artemesia vulgaris)*
- **Chinese Herbs:** Recommendation of patent, granular, and/or loose herbs from the Chinese Materia Medica
- **Electroacupuncture:** Using very small amounts of electricity to stimulate specific acupuncture points.
- **Infrared Heat:** Applying heat generated by an infrared lamp over a specific area of the body.
- **Cupping:** Glass cups are placed on the skin with a vacuum created by heat or suction device.
- **Acupressure:** Traditional Chinese medical massage and manual therapy.
- **Liniments, Oils, Plasters:** Herbal formulas applied topically to the skin.
- **Dietary Advice:** Suggestions for nutrition and herbal food products.

I recognize the potential benefits and risks of these procedures, including but not limited to:

Potential Benefits: Drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.

Potential Risks: Discomfort, pain, bruising, burning, bleeding, infection at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment.

Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to receiving treatment.

Financial Terms - Payment is expected following treatment. Treatment fees are as follows unless otherwise arranged: Acupuncture - $240 for the first visit and then $120 thereafter. The treatment fees do not include the cost of herbs or supplements. Please make your payment in full using either check or cash after the treatment. If you are unable to keep an appointment, please notify me at least 24 hours before the scheduled date or it will be necessary to pay the full appointment fee.

With this knowledge, I voluntarily consent to the above procedures and financial terms, realizing that no guarantees have been given to me by David A. Tucker regarding cure or improvement of my condition. I hereby release David A. Tucker from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

______________________________________ ________________

Signature of patient (or guardian if under 18) **Date**

David A. Tucker received his Master's Degree in Acupuncture and Oriental Medicine from Bastyr University in 2005. He has passed the National Board Examination for Oriental Medicine administered by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) and is designated a Diplomate of Oriental Medicine. He is a Licensed Acupuncturist in the State of Washington, holding Acupuncture License number AC2826, active from 2005. David received his massage training from the Brenneke School of Massage and has passed the National Certification Exam through the National Certification Board for Therapeutic Massage and Bodywork (NCBTMB). He is a Licensed Massage Practitioner in the State of Washington, holding Massage License number MA19464, active from 2003.

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing The Zen of Healing. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- This office **does not** verify insurance benefits. It is ***strongly recommended*** that each patient call their insurance carrier and have their benefits clarified to them including but not limited to – applicable co-pay, co-insurance, deductibles, # of visits, pre-authorization needed, etc.; we will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Co-pays are due at the time of service.
- Patients are responsible for payment of co-pays, co-insurance, deductibles, standard units of time, and all other procedures or treatments not covered by their insurance plan.
- Patients are responsible for all costs care, regardless of insurance coverage and all balances are due upon receipt of our statement unless a payment plan has been established with the billing department.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Charge for returned checks
  - Charge for missed appointments without 24-hours notice
- Balances unpaid after 30 days are assessed interest at 1% per month on the outstanding balance or a $3 billing fee (whichever is greater)
- Unpaid balances past 90 days may be assigned to a collection agency. Accounts assigned for collection are assessed the balance, plus collection and/or attorney fees and MUST be settled directly with the collection agency.

By my signature below, I hereby authorize assignment of financial benefits directly to The Zen of Healing and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

Signature: ________________________________ Date: ___________________________

David A. Tucker, MSAOM, L.Ac, LMP
Patient Health History

Name: ____ Date: ______/______/______
(first) (middle) (last)

Date of Birth: _______/_______/_______ Age: _______ Gender: M / F / Transgender `Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete picture of the patient. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? For what reason?

____

2. Please identify the health concerns that have brought you here, in order of importance below:

Condition **Past Treatment**

a. ____________________ ______________________________________

b. ____________________ ______________________________________

c. ____________________ ______________________________________

d. ____________________ ______________________________________

3. Please list other clinicians or practitioners you are currently under the care of:

Name **Modality** (i.e. MD, ND, Chiropractor, Counselor, etc.) **Contact**

a. ____________________ ______________ ____________________

b. ____________________ ______________ ____________________

c. ____________________ ______________ ____________________

d. ____________________ ______________ ____________________

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

Name	Dose/Frequency	Reason	Name	Dose/Frequency	Reason

6. **Family History:**

<u>Check those applicable</u>:

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	______	______	______	______	______	______
Cancer	______	______	______	______	______	______
Diabetes	______	______	______	______	______	______
Heart Disease	______	______	______	______	______	______
High Blood Pressure	______	______	______	______	______	______
Stroke	______	______	______	______	______	______
Mental Illness	______	______	______	______	______	______
Asthma/Hay fever/Hives	______	______	______	______	______	______
Kidney Disease	______	______	______	______	______	______
Age (at death)	______	______	______	______	______	______
Cause of Death	______	______	______	______	______	______

7. **Height:** __________ **Weight:** Currently: __________ Past Maximum: _________ When? __________________

8. **Blood Pressure:** What is your most recent blood pressure reading? _______/_______ When was this reading taken? ________

9. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

10. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: ____

11. **History of Traumas:** ____

____

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
______	______	______	______
______	______	______	______
______	______	______	______

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
______	______	______	______
______	______	______	______
______	______	______	______

14. Do you have any reason to believe that you are pregnant? Y N If so, how far along are you? _________

Review of Body Systems

15. Skin *(check all that apply)*

	Current	Past	*Notes (office use)*
Acne			
Bruising			
Eczema			
Itching/Dryness			
Hives			
Jaundice			
Psoriasis			
Rashes			
Skin Changes			
Excessive Sweating			
Night Sweating			
Hair/Nail Changes			

16. Head, Eye, Ear, Nose, and Throat *(check all that apply)*

	Current	Past	*Notes (office use)*
Headaches			
Migraines			
TMJ/Jaw Problems			
Teeth Grinding			
Blurry Vision			
Glasses/Contacts			
Floaters in field of vision			
Tearing/Dryness			
Eye Pain/Strain			
Glaucoma			
Earaches			
Ear Ringing			
Impaired Hearing			
Nose Bleeds			
Sinus Problems			
Hay Fever			
Frequent sore throats			

17. Blood, Lymphatic, Cancer, HIV *(check all that apply)*

	Current	Past	*Notes (office use)*
Anemia			
Bleeding Easily			
Enlarged lymph nodes			
Transfusions			
Cancer			
HIV or AIDS			

18. Musculoskeletal *(check all that apply)*

	Current	Past	*Notes (office use)*
Arm or Hand Pain			
Arthritis - Rheumatoid			
Arthritis - Osteo			
Back Pain (circle below) Upper Middle Lower			
Joint Pain Where? ____________			
Leg or Foot Pain			
Muscle Spasm/Cramp			
Neck/Shoulder Pain			

19. Neurological *(check all that apply)*

	Current	Past	*Notes (office use)*
Loss of Balance			
Numbness/Tingling			
Paralysis			
Seizures/Epilepsy			
Vertigo/Dizziness			

20. Cardiovascular *(check all that apply)*

	Current	Past	*Notes (office use)*
Chest Pain			
Heart Disease			
Heart Murmurs			
High Blood Pressure			
Palpitations/Fluttering			
Stroke			
Swelling of Ankles			
Varicose Veins			

21. Respiratory *(check all that apply)*

	Current	Past	*Notes (office use)*
Asthma			
Difficulty breathing			
Emphysema			
Frequent Colds			
Persistent Cough			
Pneumonia			
Shortness of breath			
Tuberculosis			
Other:			

22. **Gastrointestinal** *(check all that apply)*

	Current	Past	*Notes (office use)*
Acid Reflux			
Belching			
Heartburn			
Changes in Appetite			
Constipation			
Diarrhea			
Stomach rumbling			
Epigastric Pain			
Abdominal Pain			
Flank Pain			
Gall Bladder Disease			
Liver Disease			
Hepatitis B or C			
Hemorrhoids			
Passing Gas			
Nausea/Vomiting			
Ulcers			

23. **Genito-Urinary Tract** *(check all that apply)*

	Current	Past	*Notes (office use)*
Blood in Urine			
Frequent Urination			
Frequent Night Urination			
Frequent UTI			
Heavy Flow			
Impaired Urination			
Kidney Disease			
Kidney Stones			
Painful Urination			

24. **Endocrine** *(check all that apply)*

	Current	Past	*Notes (office use)*
Diabetes Mellitus			
Hyperthyroid			
Hypoglycemia			
Hypothyroid			
Tendency to be more HOT or COLD *(please circle)*			
Preference for HOT or COLD *(please circle)*			
Aversion to HOT or COLD *(please circle)*			

25. **Female Reproductive/Breasts** *(check all that apply)*

	Current	Past	*Notes (office use)*
Bleeding btw. Cycles			
Clotting			
Heavy Flow			
Absence of Flow			
Spotting			
Irregular Cycles			
Painful Periods			
Premenstrual Problems			
Vaginal Discharge			
Menopausal Syndromes			
Difficulty Conceiving			
Breast Lump/Tenderness			
Nipple Discharge			

26. **Menstrual/Birthing History**
(please fill in appropriate boxes)

		Notes (office use)
Age of First Menses		
Length of Cycle		
# of Days of Menses		
# of Pregnancies		
# of Live Births		
# of Miscarriages		
# of Abortions		

27. **Male Reproductive** *(check all that apply)*

	Current	Past	*Notes (office use)*
Penile Discharge			
Prostate Problems			
Erectile Dysfunction			
Testicular Pain/Swelling			

28. **Sexual History** *(check all that apply)*

	Current	Past	*Notes (office use)*
Problems with Libido			
Contraceptive Use Current: ________________________ Past:____________________________			
History of STDs Current: ________________________ Past:____________________________			

Is there anything else we should know? ____

____

29. **Lifestyle:**

a. Are you currently in a relationship? Y N

b. Do you have any restrictions on your diet? Y N If so, please indicate? ____________________

c. Do you have cravings for a particular food or flavor (i.e. sweet, salty, etc.)? ____________________

d. Exercise routine: ____

e. Spiritual practice: ____

f. How many hours per night do you sleep? ______ What time do you go to bed? _________ Do you wake rested? Y N

g. Occupation: ____________________ Employer: ______________ Hours/Week: _______

Do you enjoy work? Y/N Why/Why not? ______________________________

h. Nicotine/Alcohol/Caffeine Use: ______________________________

i. Recreational Drug Use:

Current: __________ Past: (include when? for how long?) ______________________________

j. How many glasses (8oz.) of each do you drink per day? Soda: _____ Juice: _____ Tea: _____ Water: _____

k. Interests, hobbies: ____

Additional Notes (Office use)

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Notice of Patient Privacy Policy

Dear Valued Patient,

This notice describes this office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from this office, I may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, I gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information that has collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

I value our relationship, and respect your right to privacy. If you have questions about these privacy guidelines, please call during regular business hours at 206-696-1121.

Yours truly,

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Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by David A. Tucker, L.Ac, LMP for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by David A. Tucker, L.Ac, LMP may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. David A. Tucker, L.Ac, LMP is not required to agree to the restrictions that I may request. However, if he agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that David A. Tucker, L.Ac, LMP has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review David A. Tucker, L.Ac, LMP Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations under David A. Tucker, L.Ac, LMP. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and David A. Tucker, L.Ac, LMP with respect to my identifiable health information.

David A. Tucker, L.Ac, LMP reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

____ ____________________

Signature of Patient or Authorized Representative Date

____

Printed Name and Relationship